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Lodgment and Details

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Important information

This Notice has been inserted as the first page of the document which has been accepted for electronic filing. It is now taken to be part of that document for the purposes of the proceeding in the Tribunal and contains important information for all parties to that proceeding. It must be included in the document served on each of those parties.

RBB Economics

Privileged and Confidential

Honeysuckle Health and nib authorisation

Expert Report

George Siolis, 14 June 2022

Contents

1 Introduction

1 In this report I assess the likely economic effects of granting authorisation to Honeysuckle Health (HH) and nib (the authorisation applicants) to form and operate a buying group (HH Buying Group). The purpose of the HH Buying Group is to collectively negotiate and manage contracts with healthcare providers (including hospitals and medical specialists) on behalf of private health insurers (PHIs) (the proposed conduct).

2 The Australian Competition and Consumer Commission (ACCC) has granted authorisation conditionally on the HH Buying Group not supplying services to the four largest PHIs (Major PHIs) (the ACCC's condition).[1] The authorisation is currently being considered by the Australian Competition Tribunal (the tribunal), following an application from the National Association of Practising Psychiatrists (NAPP) and the Rehabilitation Medicine Society of Australia and New Zealand Ltd (RMSANZ) (the applicants).

3 The Australian Medical Association (AMA) has instructed me to address the following questions:

- whether, and how, the proposed conduct (in any relevant market) may result in any public benefits and/or public detriments;
- whether the imposition of any conditions would be likely to prevent or limit any public detriments identified and, if so, to what extent; and
- whether you consider the fact that the Authorisation Applicants have submitted a template contract without confirming that it represents the final version of the MPPA to be used, affects any of your conclusions.

4 My instructions also state that due to the limited time in which I have to prepare my expert report, I am not instructed to carry out a comprehensive market definition analysis of any relevant markets.

5 I understand that the legal standard for authorisation is the net public benefit test. According to this test, the benefits (which are broadly defined as anything of value to the community including the achievement of economic efficiency) and detriments (which is any impairment including the loss of economic efficiency) to the public likely generated by the creation of the HH Buying Group should be compared and authorisation should be granted only if the former exceed the latter.

6 The remainder of this report is structured as follows:

- Section 2 sets out my understanding of how the HH Buying Group will operate and the key features in the market in which it will operate.
- Section 3 presents the likely detriments generated by the creation of the HH Buying Group. I find three ways in which the conduct is likely to lead to long-term detriment by limiting

[1] These are Medibank, Bupa, HCF and HBF WA.

doctors' clinical independence, distorting economic incentives (due to a potential misinterpretation of claims' data) and increasing administrative burden on healthcare providers.

- First, the conduct will likely make the demand of medical services more concentrated and powerful relative to medical specialists. If this were the case, PHIs will likely push the fees for medical services below current market rates. As a response to lower fees, I would expect providers to cease providing the same number of consultations under MPPAs and to expose more patients to gap payments. This translates into public detriments in the form of achieving a less efficient outcome (namely, the under-provision of medical services).
- Second, the conduct will likely lessen competition on the supply of private health insurance. Through information sharing and by standardising input costs across PHIs, the proposed conduct will likely weaken PHI's incentives to compete.
- Third, the conduct has the potential to eliminate the existing constraint that prevents the Major PHIs from turning to value-based contracting, with the consequence that the industry as a whole rapidly converges to value-based contracting. To the extent that smaller PHIs will be allowed to join the HH Buying Group, the proposed conduct will mean that those smaller PHIs turn to value-based contracting which will likely trigger a reaction from the Major PHIs which, in turn, will result in value-based contracting becoming the norm. To the extent that there might be some long-term detriments to the public associated with PHIs relying exclusively on value-based contracting, this would lead to detriments in both the short- and long- term.

In addition to these detriments, the industry-wide shift in both the balance of bargaining power between specialists and PHIs and the shift to value-based contracting triggered by the proposed conduct might also generate short-term detriments in the form of frictions between PHIs and providers in adjusting to this new negotiating model. This might translate into a temporary under-provision of medical services (and possibly higher out-of-pocket expenditure from patients).

- Section 4 considers the potential benefits of the HH Buying Group.
- Section 5 contains some economic considerations on the application of the net public benefit test.

2 The proposed conduct

2.1 The HH Buying Group

7 nib is a major private health insurer which supplies private health insurance policies to Australian residents. Currently, nib supplies approximately 10% of private health insurance policies at a national level. At a state level, nib's share ranges from 3% in Tasmania to 15% in New South Wales/Australian Capital Territory.[2]

8 HH is a health services and data science company. HH was established as a joint venture between nib and Cigna Corporation (Cigna), a global health services company. nib and Cigna each own 50% of HH. nib and Cigna say that HH acts independently of its owners.[3]

9 In October 2020, nib appointed HH to provide data analytics, contract negotiation, procurement, and administration services in relation to nib's contracts with hospitals, medical specialists, general practitioners, and allied health professionals.

10 On September 2021 the ACCC conditionally authorised nib and HH to form a joint buying group and provide the services broadly described in paragraph 9 above to PHIs and other healthcare payers (such as international medical and travel insurance companies, and government and semi-government payers of healthcare services). Authorisation was granted for a period of five years and subject to the condition that the HH Buying Group must not supply any services to Major PHIs.

11 In this report I focus on services offered to PHIs in relation to (i) contracting with hospitals and (ii) contracting with medical specialists.

2.2 Background

12 There are currently 36 PHIs in Australia.[4] Major PHIs all manage contracting with healthcare providers internally. HH manages nib's contracts. The remaining 31 smaller PHIs engage in collective bargaining with hospitals and medical specialists through one of two existing buying groups - 27 health insurers are part of the Australian Health Services Alliance (AHSA) and 4 health insurers are part of the Australian Regional Health Group (ARHG).[5] Table 1 below presents PHI market shares based on the number of insurance policies.

[2] See table 2 in AMA's application to intervene.
[3] See Authorisation Applicant's Statement of Facts, Issues and Contentions, §6.
[4] See Authorisation Applicant's Statement of Facts, Issues and Contentions, §34(a).
[5] See the ACCC's determination, §2.1.

Table 1: PHI Market share for 2020-2021

	NSW/ACT	VIC	QLD	WA	SA	TAS	NT	Total
Medibank	22.77%	31.09%	30.38%	21.86%	19.69%	25.22%	40.25%	26.06%
BUPA	21.98%	22.55%	30.26%	10.74%	45.46%	29.81%	34.81%	24.19%
HCF	20.69%	8.33%	9.11%	6.09%	10.12%	6.54%	7.22%	12.56%
NIB	15.20%	9.01%	7.13%	4.36%	4.53%	3.28%	3.59%	9.74%
HBF	0.79%	1.21%	0.79%	48.19%	0.50%	0.80%	1.55%	6.78%
Other funds	19.37%	29.02%	23.12%	8.76%	20.20%	35.15%	14.14%	27.45%

Source: Table 2 in AMA's application to intervene. Based on APRA's operational data for 2020-2021

13 The Major PHIs collectively and nib account for around 70% and 10% of health insurance policies in Australia, respectively. The share of health insurance policies covered by the Major PHIs and nib differ across states and it is highest in Western Australia (91%).[6] Individuals can subscribe to private health insurance policies issued by PHIs by paying premiums. In exchange for those premiums, PHIs will pay healthcare providers whenever individuals receive treatments.[7] However, healthcare providers may also collect additional amounts from patients. These additional amounts of out-of-pocket expenditure are referred to as "gaps".

14 Healthcare services provided to privately insured patients are typically charged at either the Medicare Benefits Schedule (MBS) fee or above it. MBS fees are set and subsidised by the Federal Government for each medical service. All medical specialists have a statutory right to be paid for their services. Of that Scheduled Fee under the Medicare Benefits Schedule, 75% is required to be paid by Medicare and 25% is paid by PHIs under section 72-1 of the *Private Health Insurance Act 2007* (Cth). If only the Scheduled fee is charges, there is no out-of-pocket expenditure for the patient (i.e., there are no "gaps").

15 Specialists may set a higher fee than the Scheduled Fee, in which case the patient may be liable to pay the "gap" (unless the specialist has a "no gap" agreement with the patient's PHI).

16 These agreements are called "hospital purchaser provider agreements" (HPPAs) and "medical purchaser provider agreements" (MPPAs) depending on whether they are negotiated with hospitals or individual medical specialists. They are used by health insurers to provide financial certainty to patients in relation to potential out-of-pocket costs.

17 HH has also established a particular agreement with medical specialists called the Broad Clinical Partners Program (BCPP). Under this program, HH enters into agreements with multiple medical specialists to ensure that patients are not charged out-of-pocket costs for medical services provided during an episode of hospital treatment. Essentially, a BCPP consists of multiple individual MPPAs negotiated with all the specialists involved in a particular

[6] See table 2 in AMA's application to intervene. Reference to the Major PHIs in this paragraph includes HBF as a whole.
[7] Out-of-hospitals medical services are not covered by private health insurance.

treatment. It ensures that the patient is charged no or a set gap over the whole course of a treatment. Currently BCPP agreements exist only for joint replacement surgery.

18 BCPP differs from other medical "no or known" gap schemes (like MPPAs) in two aspects. First, it covers all the specialists involved in a whole episode of hospital treatment (e.g., for knee replacements: orthopaedic surgeons, anaesthetists and assistant surgeons). Second, medical specialists agree to treat all of nib's customers through the program while, in other medical gap schemes, specialists can opt in and out of the scheme on a per patient basis.

2.3 Services provided by the HH Buying Group

19 The HH Buying Group will seek to extend the HPPAs and MPPAs agreed on behalf of nib to all participating PHIs. This will involve collective negotiations with providers. Once HH and a provider agree on terms and conditions, a participating PHI can decide whether to enter an HPPA or MPPA based on the terms and conditions negotiated by HH. If it does, HH will undertake contract administration for the agreement. If it decides not to, the PHI can negotiate directly with the provider.[8]

20 Similarly, the HH Buying Group will attempt to expand the BCPP to participating PHIs (customers of participating PHIs will receive the same benefits as nib customers when treated by medical specialists already participating in the BCPP). Moreover, it will also seek to enlarge the scope of the BCPP by entering into agreements with more specialists to cover additional types of treatment (rather than just joint replacement surgery).[9]

21 In addition to contract negotiations, the HH Buying Group will also provide data analytics services to its members. Specifically, it will collect and aggregate the claim data of participating PHIs. It will then undertake data analysis to benchmark providers in terms of service, price and application of services and will share the results of that analysis with the PHIs. This will provide PHIs with information about the performance of individual providers, benchmarked against aggregated data from across the HH Buying Group. This information will also be used when negotiating with providers.

22 Finally, the HH Buying Group will provide contract administration and dispute resolution services to its members.

2.4 Features of the HH Buying Group

23 As mentioned above, PHI buying groups already exist in Australia. These are AHSA (which includes 27 PHIs) and ARHG (which includes 4 PHIs). They engage in collective negotiations with providers on behalf of smaller PHIs. (The Major PHIs contract with providers independently.)

24 I understand, however, that the HH Buying Group will be significantly different from what is currently seen in the market. First, whilst AHSA and ARHG are non-profit organisations that

[8] See Authorisation Applicant's Statement of Facts, Issues and Contentions, §29.
[9] See Authorisation Applicant's Statement of Facts, Issues and Contentions, §24.

mostly provide back-office support to smaller PHIs, the HH Buying Group is a joint venture between two entities that will seek to profit from the services they provide.

25 Second, and more importantly, the services proposed by HH are unique in several aspects and introduce a number of novel features to the market. Specifically, the HH Buying Group will make extensive use of advanced data analytics which will provide PHIs with information on providers' performances. While Major PHIs and members of existing buying groups might already make use of some types of data analytics, drawing on HH's data capabilities, the services offered by the HH Buying Group will be more sophisticated and based on advanced techniques.[10]

26 Importantly, such advanced data analytics will be instrumental in expanding an alternative contracting model. While existing buying groups and Major PHIs currently focus exclusively on the cost of care to determine practitioners' fees, the HH Buying Group will rely on value-based contracting.[11] According to this model, the prices for services negotiated by PHIs will be informed by the clinical and patient-reported outcomes of those services relative to the cost of care to achieve those outcomes. This model aims at incentivising better healthcare in circumstances where it reduces costs to PHIs and costs to patients. BCPP already includes some aspects of value-based contracting, so its intended expansion will make value-based contracting more prevalent. Advanced analytics will underpin this model by providing information about the performance of each provider (benchmarked against average outcomes).

27 I understand that all smaller PHIs are part of a single buying group (either AHSA or ARHG) and use either of those buying groups for all their needs. Therefore, if the HH Buying Group were to be authorised and gained members, those members would come at the expense of AHSA and ARHG. Major PHIs will have to consider whether to continue contracting with healthcare providers internally or to join the HH Buying Group. I understand that the authorisation applicants believe that the HH Buying Group will provide benefits to PHIs in terms of more sophisticated data analytics and reduced costs thanks to value-based contracting.[12] Despite these benefits, the authorisation applicants claim that the participation fee will be competitive with the AHSA's or ARHG's membership fees.[13]

28 In light of these considerations, it is reasonable to expect that a number of (and potentially all) smaller PHIs will decide to leave AHSA and ARHG and join nib in the HH Buying Group. Some of the Major PHIs might also decide to start relying on the services offered by the HH Buying Group. Depending on which PHIs will decide to join the HH Buying Group, the HH Buying Group has the potential to easily account for more than half of the insurers' market (in terms of number of policies). For example, based on the shares presented above, if only HBF joined the HH Buying Group, the HH Buying Group would account for 53% of policies in Western Australia.

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10 See Authorisation Applicant's Statement of Facts, Issues and Contentions, §46(b).
11 See Authorisation Applicant's Statement of Facts, Issues and Contentions, §26.
12 See Amended Application for Authorisation, §4.12.
13 See Amended Application for Authorisation, §4.8.

3 The likely detriments generated by the proposed conduct

29 My understanding is that conduct cannot be authorised unless it is satisfied, in all of the circumstances, that the conduct would result or be likely to result in a benefit to the public, and the benefit would outweigh the detriment to the public that would be likely to result. Given that the proposed contract is a template contract and potentially subject to change, the potential benefits and detriments may also change. But based on my review of the nature of the industry and of the proposed template contract, I find that the authorisation is likely to generate detriments resulting from:

a. the HH Buying Group gaining market power and tilting the balance of bargaining power relative to healthcare providers, and medical specialists in particular;

b. the lessening of competition among PHIs; and

c. to the extent that there are detriments associated with value-based contracting, from the proposed conduct leading to a more accelerated take-up of value-based contracting than would be the case without that conduct.

3.1 The increase in HH's buyer power leads to an inefficient market outcome

30 I believe that detriments are likely to materialise due to the HH Buying Group gaining significant market power relative to healthcare providers.

31 Economic theory indicates that competitive markets deliver the largest surplus for society. Non-competitive markets, on the other hand, deliver inferior outcomes. A monopolist, for example, will charge a price that is too high (i.e., above efficient levels). While this benefits the monopolist, society as a whole suffers a loss due to lower output being produced.[14]

32 Losses can similarly arise when the demand side is too concentrated relative to supply, and suppliers have little market power. Even if there are multiple entities demanding the service, suppliers will be forced to accept the price offered by buyers. In these situations, society suffers the loss as the market will reach a price that is too low and the good is under-provided.[15]

33 In the case at hand, medical services are supplied by healthcare providers and purchased by either PHIs or buying groups (on behalf of PHIs). As pointed out above, given the benefits that the authorisation applicants claim the group will bring to PHIs, it is to be expected that the HH Buying Group will bring together a significant number of PHIs. Indeed, all the smaller PHIs that are currently part of the two existing buying groups will have incentives to join the HH Buying Group. If only all smaller PHIs joined the HH Buying Group, this would lead to a

[14] The intuition is that, not being constrained by rivals, the monopolist will charge a unit price which is above its cost of production. This implies that a portion of consumers who are willing to pay a price higher than the cost of production, but lower than the market price, will not be supplied.

[15] The intuition is that if one supplier tried to raise its price, the buyer would just buy from a different seller. As for the monopolist case, society will experience a loss as some consumers value the resource more than its cost of production but are not supplied.

significant increase in concentration of demand for medical services, with fewer entities representing larger portions of patients. Based on the shares presented above, the HH Buying Group will represent more than 37% of policies at a national level. This means that more than 87% of the demand at a national level will be concentrated in the hands of only three entities (the HH Buying Group, Medibank and BUPA). The increase in concentration will be even more prominent is some states. In Queensland, for example, each of Medibank, BUPA and the HH Buying Group (including nib and all smaller PHIs) will represent one third of the demand of medical services. Obviously, the increase in demand concentration that will follow the authorisation will be even more significant if even one of the Major PHIs will join the HH Buying Group.

34 If the authorisation will result in a more concentrated demand (as it is likely to be the case), public inefficiencies will likely materialise. Being more concentrated and powerful, the demand side might push to reduce fees or fee reimbursements paid to providers. In response to lower fees, I would expect providers to supply fewer services or consultations under MPPAs meaning that some policy holders would incur a "gap" payment.[16] This would represent an inefficiency.

35 The inefficiencies generated by an increase in the market power on the demand side will mostly adversely affect medical specialist contracting. While hospitals are sophisticated entities, medical specialists are atomistic agents with limited resources to be dedicated to negotiations with PHIs. Medical specialists have less market power relative to large buying groups to begin with.[17] Therefore, even a relatively small increase in the concentration of the demand side is likely to push the market to a sub-optimal equilibrium where the price of medical specialist services is artificially low causing medical services to be under-provided and greater pressure placed on the public system.

36 Importantly, I note that the Private Health Insurance Act 2007 (PHI Act) will not be able to constrain the market power of buying groups relative to healthcare providers (and, particularly, to medical specialists) resulting from an increase in demand for medical services. The PHI Act, among other things, includes an obligation for PHIs to pay at least 25 per cent of the MBS fee charged by a practitioner. This obligation does not increase providers' market power relative to buying groups. It does not give providers any credible threats that could be leveraged when negotiating with PHIs. This is because, while it makes the PHI always liable to pay part of the patient's fees, charging MBS fees represents a loss (or foregone profit) for providers. This is evidenced by the fact that in most cases providers charge fees higher than the MBS fees. APRA's operational data for March 2022 indicate that only 5% of the total services provided in Australia are charged at the MBS fee.[18] For the remaining 95%, practitioners charge a fee which is above the MBS fee. It is thus unreasonable to believe that charging MBS fee is a credible threat in the hand of providers in face of buying groups. The PHI Act also does not prevent the possibility that PHIs will nudge their patients away from providers not agreeing to their terms.

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16 This simply follows from the law of supply whereby, as the market price of a service increases, the quantity of the service that suppliers will offer will increase (and vice-versa).

17 In economics, they might be referred to as "*price-take*s", they either accept the price offered by buyers or they will not be able to supply.

18 *Available online at: https://prod.apra.shared.skpr.live/quarterly-private-health-insurance-statistics*

3.2 Lessening of competition on the supply of private health insurance

37 The proposed conduct may also generate detriments by lessening competition in the market for the supply of private health insurance to consumers.

38 The proposed conduct has two main economic effects on insurers. On the one hand, it provides the same set of information to all its members (information sharing). On the other hand, it effectively standardises the input cost of all its members - in this case, practitioners' fees (standardisation of input costs). These effects have the potential to reduce economic incentives for PHIs to compete with each other.

39 The economic theory of collusion indicates that both effects on insurers generated by the proposed conduct can lead to or facilitate coordinated behaviour. First, the degree of transparency in a market is a key element affecting the sustainability of a cartel. A high degree of transparency in a market can help sustain coordinated behaviour by facilitating the detection of deviating firms. The more information cartel members have about their rivals, the easier it is to check whether every member is sticking to the collusive agreement (and consequently punish deviating firms). The proposed conduct involves a great extent of information sharing among PHIs which might lead to or facilitate collusion. Importantly, this will happen even if the shared information does not contain customer information or marketing strategies. Any type of data which provides information on the behaviour of each PHI (e.g., in terms of number of customers covered, fees paid to providers etc.) could be instrumental in sustaining a collusive behaviour.

40 Second, coordinated behaviour could be facilitated by an enhanced symmetry in input costs. Economic theory indicates that differences in marginal costs among would-be cartel members will tend to make it more difficult for those cartel members to reach a collusive agreement. Conversely, having identical marginal costs (i.e., collectively negotiated practitioners' fees) might make it easier for insurers to coordinate. Essentially, by standardising input costs of PHIs, the proposed conduct will eliminate one dimension of competition, making it easier for PHIs to coordinate.

41 Moreover, uncertainty about rivals' costs gives each supplier incentives to reduce their marginal costs (for example, through innovation). If all suppliers know that they will all share identical marginal costs, they have weaker economic incentives to try to become more efficient. In this sense, the HH Buying Group will reduce the incentive to innovate. For example, absent the proposed conduct small PHIs might have an incentive to develop their own type of data analytics within the two existing buying groups.

42 In the long term, if the HH Buying Group were to represent all smaller PHIs (so that AHSA and ARHG will cease to exist), the scope of the effects just described will be enlarged by the proposed conduct as information will be shared and input costs will be standardised across a larger number of PHIs.

3.3 Introduction of value-based contracting

43 One of the rationales for the creation of the HH Buying Group is the expansion of value-based contracting in Australia. At the outset, it is important to observe that:

a. Value-based contracting is currently not prohibited from a regulatory point of view in Australia;

b. HH believes that value-based contracting is economically profitable. Being a for-profit entity, it would not seek to expand this alternative model unless it deemed it to be profitable for the group itself and for participating PHIs (e.g., in terms of generating increased premiums or lower costs); and

c. Interested parties are concerned about the introduction of value-based contracting which is seen as a way to introduce a US-style managed care in Australia.[19]

44 Significantly, despite potentially having the necessary capabilities, at present the Major PHIs do not rely on value-based contracting to any significant extent.

45 It is reasonable to believe that the presence of the smaller PHIs (acting collectively via the two existing buying groups) operating the traditional model currently deters the Major PHIs from switching to value-based contracting. This is because, if the Major PHIs alone were to introduce this model, providers would still have the option of working with smaller PHIs operating according to the traditional model based on cost of care. With this alternative available, providers will be less likely to enter value-based contracts with Major PHIs (or if they do, they will likely be able to negotiate better terms). Anticipating this response from providers, Major PHIs might currently be reluctant to aggressively switch to value-based contracting. Granting authorisation to the proposed conduct will change the way that these prevailing competitive constraints operate. As set out above, it is to be expected that at least some (and possibly all) smaller PHIs will join the HH Buying Group. They have economic incentives to do so, as joining the HH Buying Group will give them the possibility of benefitting from value-based contracting - which would not be possible without HH's data capabilities.

46 In other words, the proposed conduct alters the nature of the buying group in the market. Smaller PHIs will no longer rely on a buying group that essentially only provides back-office support. Instead, they will now be part of a group that will rely more heavily on value-based contracting.

47 According to this theory of harm, granting authorisation has the potential to eliminate the existing constraint that prevents the Major PHIs from turning to value-based contracting, with the consequence that the industry as a whole rapidly converges to value-based contracting. In this scenario, the traditional contracting model based on cost of care will be completely replaced by value-based contracting. In other words, the proposed conduct might weaken rather than strengthen competitive constraints among PHIs, and specifically between smaller PHIs and the Major PHIs. By allowing smaller PHIs to engage in value-based contracting (through the HH Buying Group), the proposed conduct will eliminate the competitive pressure

[19] See summary of concerns from interested third parties contained in the ACCC's determination, §3.11 and following.

that is currently preventing the Major PHIs from switching contracting model. It is reasonable to believe that such lessening of competition among PHIs will generate a market outcome (which is value-based contracting being the only contracting model) that would not have occurred absent the proposed conduct.

48 I was not instructed to assess the benefits (or detriments) of the value-based contracting model relative to existing models. I note however that there might be some long-term detriments to the public associated with PHIs relying exclusively on value-based contracting. From the section of the ACCC's determination titled "*Introduction of US-style managed care in Australia*", I understand that interested parties are concerned that value-based contracting might generate detriments such as (i) PHI interference with medical independence, (ii) misinterpretation of claims data, and (iii) increased administrative workload and stress for doctors. Each of these broad concerns are developed in detail throughout the applicants' submissions. For example, the statement of Dr Gary Alexander Galambos (on behalf of NAPP) discusses the detriments associated with an increased PHI involvement in the treatment of patients with mental health issues.[20] Similarly, the statement of Margaret Annette Faux highlights how "*the evidence suggests that the [HH Buying Group] application is likely to worsen medical practitioner compliance challenges, because it adds another layer to an already chaotic regulatory environment"*.[21]

49 Based on my review of the nature of the industry and of the proposed conduct, if value-based contracting has the potential to generate such long-term detriments, then these should be considered to be potential detriments of the proposed conduct.

50 Finally, I believe it is significant that the detriments generated through the mechanism described above would not require any of the Major PHIs to join the HH Buying Group. No longer being constrained by smaller PHIs, I find it reasonable to expect that the HH Buying Group and Major PHIs will pursue a similar policy with respect to specialists (i.e., value-based contracting). This is likely to give rise to a substantial cumulative effect in the market. Consequently, the detriments could not be avoided simply by prohibiting the HH Buying Group from supplying the Major PHIs.

3.4 Risk of detriment in the long-term and the short (and medium)-term

51 As described in the previous three sub-sections, the proposed conduct might lead to detriments **in the long-term** through three different mechanisms.

52 First, the proposed conduct is likely to lessen competition between smaller PHIs and the Major PHIs in a way that will make the industry converge to value-based contracting as the only available contracting model. I understand from interested parties that this might have long term negative consequences per se which would represent a detriment.

53 Second, the proposed conduct is likely to lessen competition on the supply of private health insurance by expanding the scope of information shared across PHIs and standardising input

[20] See §42 and following.
[21] See §18.

costs for PHIs. Economic theory indicates that these effects will facilitate coordinated behaviours.

54 Third, as discussed in sub-section 3.3, the proposed conduct is expected to make the demand for medical services more concentrated and powerful relative to medical specialists. If this were the case, economic theory indicates that PHIs will push the market price of medical services (i.e., fees to providers) down. As a response to lower fees, providers will supply fewer services under MPPAs which will expose policy holders to a gap payment (and higher fees). This translates into public detriments in the form of under-provision of medical services.

55 Even if it were found that an exclusive reliance on value-based contracting does not generate long-term detriments, the proposed conduct will still – in my view – likely lead to public detriments in the **short and medium term** in the form of frictions between PHIs and providers in adjusting to the change in the balance of bargaining power and/or this new negotiating model.

56 An industry-wide switch to value-based contracting (as well as a change in the bargaining power between PHIs and specialists) could cause inefficiencies in the form of under-provision of medical specialist services as a result of inflated out-of-pocket expenditures for patients (given that specialists provide fewer services under MPPAs). This is because providers will suddenly be faced with a new contracting model that changes dramatically the way in which they are remunerated, bringing data analytics and performance assessment into the equation.

57 I believe it is therefore reasonable to expect that there will be some adjustment costs associated with this industry-wide shift. These will likely take the form of initial disagreements between PHIs and providers. The likely occurrence of serious disagreements between PHIs and providers is shown by the fact that NAPP and RMSANZ are seeking an order from the tribunal to change the terms proposed by the authorisation applicants. In particular, they are seeking an order that prevents agreements between PHIs and providers from including, *inter alia*, (i) any target percentages for admission or treatment outcomes, and (ii) terms forcing providers to have any regards to any clinical or treatment guidelines formulated by PHIs (or their buying groups). While terms are discussed and agreed upon between PHIs and providers, medical specialists might decide to provide fewer services and charge higher gaps to patients (not being satisfied with terms first proposed by PHIs).

58 Depending on the extent and duration of this situation, the public healthcare system might also be placed under greater strain if it has to compensate for under-provision by the private sector. If these frictions will last for a longer period and medical specialists perceive that they are not remunerated fairly by PHIs, the medical profession might become relatively less appealing to young generations, causing a shortage of professionals in the future.

4 Considerations on potential benefits

59 My understanding is that, to date, the authorisation applicants have not filed any evidence with the tribunal. As such, I consider their amended application for authorisation submitted to the ACCC to represent their current views on the likely effects of the proposed conduct.

60 In this section, I comment on the benefits that the authorisation applicants claim flow from the proposed conduct. In particular I focus on the authorisation applicants' claims that the HH Buying Group is likely to bring benefits to the public in terms of (i) transaction costs savings and increased efficiencies, (ii) increased competition between buying groups and (iii) increased availability of no gap experience for customers.

61 First, I note that the authorisation applicants claim that the proposed conduct will reduce transaction costs for PHIs (and thus increase efficiencies) through collective bargaining. This cannot be considered as a benefit generated by the proposed conduct. All smaller PHIs already engage in collective bargaining through AHSA and ARHG. Their potential move to the HH Buying Group does not bring any significant benefits to the society compared to a scenario without the proposed conduct.

62 Second, as regards competition between buying groups, while economic theory indicates that competition generates efficiencies in general, the specifics of the market at hand should be considered. The PHI market is characterised by a small number of large players (that negotiate independently with healthcare providers) and many smaller PHIs that negotiate as part of established buying groups - 27 are part of AHSA; 4 as part of ARHG. In these circumstances, it is possible that the introduction of an additional buying group will have the perverse effect of reducing rather than increasing the competitive pressures faced by the Major PHIs. For example, according to the mechanism detailed in sub-section 3.3, the competitive presence of the smaller PHIs may prevent the Major PHIs from adopting a value-based contracting model.

63 Third, I find that the authorisation applicants did not sufficiently substantiate how increased availability of no gap experience will translate into a public benefit. I note that the percentage of medical services funded by PHI under a "no gap" agreement or a "no gap and no agreement" basis is high – 84% and 5% respectively for the March 2022 quarter.[22] Given that around 89% of all medical services currently enjoy a no gap experience, the authorisation applicants should explain and quantify the source and magnitude of this alleged incremental benefit.

64 Even if we assume that the HH Buying Group will expand the scope of its no gap experience (under BCPP), such increased availability will ultimately only benefit patients if a substantial share of providers decides to accept HH's terms.[23] Nevertheless, the likely response of healthcare providers should also be taken into account. Given the current disagreements on the proposed terms, it should not be taken for granted that healthcare providers will join the

[22] Statement by Dr Omar Khorshid, 14 June 2022, Table 1.
[23] It should also be considered that increased availability of no gap experience will be paid by insured patients in terms of higher premiums.

proposed no gap scheme. Therefore, the possibility that increased availability of no gap experience will likely translate into a public benefit is unsubstantiated.

65 Moreover, as I discussed in the previous section, if the whole industry were to move to value-based contracting there is a risk of under-provision of medical services caused by a PHIs exercising their market power and pushing fees to below market levels. Also, at least in the short term, public detriments might occur because of initial frictions in the change in the balance of bargaining power and/or the adoption of the new contracting model.

5 Economic considerations on the application of the net public benefit test

66 I understand that the legal standard for authorisation is the net public benefit test. According to this test, the benefits and detriments to the public likely generated by the creation of the HH Buying Group should be compared and authorisation should be granted only if the former exceed the latter. I also note that, public benefits are defined broadly as:

> *"…anything of value to the community generally, any contribution to the aims pursued by society including as one of its principal elements … the achievement of the economic goals of efficiency and progress"*[24]

whilst a public detriment is:

> "*…any impairment to the community generally, any harm or damage to the aims pursued by the society including as one of its principal elements the achievement of the goal of economic efficiency"*.[25]

67 Economics can help this balancing exercise by providing the relevant theoretical framework to assess the likelihood and magnitude of the benefits and detriments of a given practice. In particular, the application of economic principles to the specifics of a case (such as market characteristics and nature of the conduct) can provide useful insights into the likely effects of a proposed conduct.

68 In this section, I set out three further considerations that the tribunal might find helpful when undertaking the balancing exercise to apply the net public benefit test for the current matter.

5.1 Market definition

69 Defining the relevant market is widely accepted as the logical first step in any competition assessment.[26] Only once the relevant market has been defined can competition in that market be assessed.

70 To define a relevant market, it is necessary to determine the market's product dimension and geographic dimension.

71 The product market is determined by selecting an initial candidate market made up of a collection of products and considering the scope for demand-side substitution and/or supply-side substitution to constrain prices within that candidate market. In the context of the product market:

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[24] Queensland Co-operative Milling Association Ltd (1976) ATPR 40-012 at 17,242; cited with approval in Re 7-Eleven Stores (1994) ATPR 41-357 at 42,677.
[25] Re 7-Eleven Stores (1994) ATPR 41-357 at 42,683.
[26] Simon Bishop & Mike Walker, *The Economics of EC Competition Law* (Sweet & Maxwell, 3rd Ed, 2010) at page 108.

- demand-side substitution refers to the willingness and ability of buyers of goods or services in the candidate market to switch to alternative products outside the candidate market in response to an increase in prices;[27] and

b. supply-side substitution refers to the willingness and ability of suppliers of alternative products outside the candidate market to quickly and easily begin supplying products in the candidate market in response to a price increase. For the products of a firm to be regarded as supply-side substitutes, the production of those products must be possible within a relatively short period of time (often considered as up to one year) and without the need for significant investments.[28]

72 The first step in defining a geographic market is usually to identify the area in which the good or service under analysis is supplied or could readily be supplied. The next step is to identify the geographic areas where consumers would be able or willing to find substitutes for the goods or services in question. The factors that might affect the ability or willingness of customers to turn to substitutes in other geographic areas include "*the portability of the relevant good, costs to customers of obtaining supply from alternative regions, and any regulatory or other practical constraints on suppliers selling to alternative regions.*"[29]

73 The standard approach to defining a relevant market is to use a conceptual framework known as the Hypothetical Monopolist Test (**HMT**).[30,31] Under the HMT, a market is defined by starting with the smallest plausible candidate market and determining whether a hypothetical monopolist controlling all products in that candidate market would be able to profitably and permanently raise prices by a small, but significant amount, often taken to be 5 per cent to 10 per cent. If the constraints arising from demand-side substitution and/or supply-side substitution would be sufficient to render such a price increase unprofitable, then the market should be widened to include products or geographic areas previously outside of the candidate market. The test is then repeated iteratively until a price increase would be profitable, at which point the products and geographic areas within the candidate market will define a relevant market.

74 The framework provided by the HMT is widely considered to provide the basis for defining relevant markets for competition purposes.[32,33] Although the discussion above refers to a "monopolist", the same approach applies to defining a market when dealing with a monopoly buyer, who is referred to as a monopsonist. In that case, the test would consider how suppliers (such as specialists) would respond to a small, but significant *decrease* in price.

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27 Simon Bishop & Mike Walker, *The Economics of EC Competition Law* (Sweet & Maxwell, 3rd Ed, 2010) at page 118.
28 Simon Bishop & Mike Walker, *The Economics of EC Competition Law* (Sweet & Maxwell, 3rd Ed, 2010) at pages 119-120.
29 ACCC, *Guidelines on Misuse of Market Power* (August 2018) at paragraphs 2.10 and 2.11.
30 Simon Bishop & Mike Walker, *The Economics of EC Competition Law* (Sweet & Maxwell, 3rd Ed, 2010) at page 111.
31 ACCC, *Merger Guidelines* (November 2017) at pages 15-16, paragraphs 4.19-4.22.
32 Bishop & Walker state that "*[i]t cannot be stressed enough that defining relevant markets on a basis that is not consistent with the principles of the Hypothetical Monopolist Test will, almost by definition, fail to take properly into account demand-side and supply-side substitution possibilities. In consequence, any market shares calculated from such market definitions will not provide, except purely by chance, a good proxy of market power. Although the Hypothetical Monopolist Test is often proposed as one possible way of defining relevant markets, no alternative that is consistent with the principles of assessing demand-side and supply-side substitutability has been proposed*." See:
Simon Bishop & Mike Walker, *The Economics of EC Competition Law* (Sweet & Maxwell, 3rd Ed, 2010) at page 123.
33 The ACCC uses the HMT as an "intellectual aid" to help focus a qualitative approach to market definition. I consider that the ACCC's approach is consistent with my own. See:
ACCC, *Merger Guidelines* (November 2017 at pages 15-16, paragraph 4.22.

75 As I have discussed above, concerns around buyer power are not limited to cases where there is a monopsonist. Buyer power may relate to the ability of a powerful buyer to extract additional surplus from the negotiated outcomes. This may lead to less efficient contract terms and lower output.

76 The authorisation applicants have expressed their views on relevant markets at paragraph 3.2 of their Amended Application for Authorisation. Without describing the basis for their conclusion, the authorisation applicants asserted that there is "*a national market for private health insurance*". While it is not my intention here to undertake an assessment of relevant market definition, I note that this conclusion appears to overlook available evidence. Notably, Table 1 above shows that the market shares of the Major PHIs and the existing buying groups differ markedly from state to state. For example, Medibank's share varies from 20% in South Australia to 40% in the Northern Territory. Bupa's share ranges from 11% (in Western Australia) to 45% (in South Australia). HBF's share is 48% in Western Australia but below 2% in all other states. While the considerations above are not enough to conclude on the precise definition of the geographic relevant market for PHI, it provides a preliminary indication that competitive dynamics might not be uniform across states and thus a national relevant market perspective might not be justified.

5.2 The relevance of a template contract

77 My understanding is that the proposed contract is a template contract and potentially subject to change. The detriments that I set out in section 3 of my report will depend on the terms of the final contract and the response of specialists to changes in agreements. This is likely to vary by speciality and by location.

5.3 Conditions on authorisation

78 I understand that conditions can be imposed on the authorisation to ensure that the proposed conduct satisfies the net public benefit test. Specifically, conditions aim at preventing or limiting likely detriments.

79 In the current matter, having reviewed the nature of the industry and of the proposed conduct, I find that the authorisation is likely to generate detriments in three ways: (i) by increasing the market power of the demand side relative to medical specialists, (ii) by lessening competition in the supply of private health insurance and (iii) by making the industry converge more rapidly to value-based contracting (as smaller PHIs will now have the same strategic objective as larger PHIs who have been deterred from moving to value-based management under the current arrangements).

80 The applicants (the National Association of Practising Psychiatrists (NAPP) and the Rehabilitation Medicine Society of Australia and New Zealand Ltd (RMSANZ)) are seeking an order from the tribunal that prevents the Major PHIs from being supplied by the HH Buying Group with respect to medical specialists (the condition).

81 From an economic perspective, I note that the condition would limit the detriments resulting from the increased market power on the buyers' side and the reduced competition in the supply of private health insurance discussed above but would not prevent the detriment arising from the industry moving more quickly to value-based contacting. Even if (only) smaller PHIs joined the HH Buying Group, the proposed conduct may trigger a reaction from the Major PHIs which will result in value-based contracting becoming the norm. In turn, this would lead to public detriments in both the short- and long- term.

82 Finally, when considering conditions seeking to limit the increase in market power of buying groups, it is also worth noting that there are significant barriers to entry and expansion to the market in which the HH Buying Group will operate. These are not only in the form of regulatory barriers but also in terms of economic incentives.

83 Specifically, to be successful a new group will have to establish a large base of insured patients and agreements with most practitioners. To do so, it will have to offer more competitive terms than the incumbent, namely more attractive fees for practitioners and/or better services to PHIs. In economic terms, buying groups benefit from economies of scale which, depending on their cost structure and the importance of variable costs, may mean that larger groups are more competitive than smaller ones. This is because providers are more willing to enter into agreements with PHIs covering a larger number of insured patients. While this should result in lower premiums charged to patients in an (effectively) competitive market, the barriers to entry and expansion here may enable the incumbent to keep premiums high. In practice this means that, if the HH Buying Group were to be allowed to represent a large number of PHIs (possibly including some of the Major PHIs) so to be able to behave independently from its smaller rivals (as it knows that it can offer better terms due to its size), it could, if competition from major PHIs was muted or less effective, be able to extract close-to-monopoly profits for a sustained period of time before a competitor could enter and challenge the HH Buying Group.